Congress of the United States
Washington, DC 20515

September 24, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

The Ways and Means Committee began a process in July 2017 to identify and reduce Medicare regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries. Through this process we have identified multiple changes that could be made through the regulatory process to better serve Medicare beneficiaries, including seniors living in rural areas. People in rural areas are more likely than others to have lower incomes, higher unemployment rates, and higher rates of poverty.[1] Those in rural areas are also more likely to be age 65 or above,[2] yet rural communities grapple with the challenge of maintaining access to health care services given significant provider shortages, as well as limited availability of other resources such as technological expertise and transportation networks in rural areas. We applaud the Centers for Medicare and Medicaid Services (CMS) for the changes they already made through various payment regulations that are reducing the time and cost of regulatory compliance without negatively impacting patient care and urge the Administration to continue to look for ways to ease burdens for rural providers who already face additional challenges.

Specifically, we appreciate the work CMS has done to make improvements in the enforcement of the direct supervision requirement for outpatient therapy services at rural hospitals and the modified enforcement of the 96-hour requirement for Critical Access Hospitals (CAHs). We urge CMS to continue such policies in future years. We also encourage CMS to provide flexibility for co-location of providers in order to improve access to care in rural areas. Lastly, we urge CMS to make improvements to the hospital compare website to reduce confusion for beneficiaries trying to access information about rural hospitals.

Direct Supervision

We appreciate the two-year moratorium on the enforcement of the direct supervision requirement for outpatient therapy services at rural hospitals; however, we urge CMS to make this regulatory change permanent to provide hospitals certainty for long-term hiring decisions. Beginning in 2009, CMS introduced the requirement for "direct supervision" by physicians as a "restatement

[1] U.S. Department of Agriculture State Fact Sheets website. Available at http://www.ers.usda.gov/data-products/state-fact-sheets/state-data.aspx?StateFIPS=00. Last accessed January 2015.
[2] *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC: MedPAC; 2012: 115-137.

or clarification" without clear allegations or supporting evidence that quality of care or patient safety had been compromised in CAHs. CMS has the regulatory authority to make this change permanent, and we encourage CMS to do so.

96-Hour Rule

We are pleased that CMS has continued the modified enforcement of the 96-hour condition of payment in the 2018 Hospital Inpatient Prospective Payment System (IPPS) payment rule. Strict enforcement of the 96-hour condition of payment requires physicians at CAHs certify at the time of admission that a Medicare patient will not be at the facility for more than 96-hours, a difficult certification in some instances that encourages physicians to transfer patients when care could be provided locally, especially for certain general surgical services that may be provided at CAHs. Congressional intent to provide CAHs greater flexibility was evident in the 1999 modification of the 96-hour condition of participation from a hard 96-hour cap to a flexible annual average. Accordingly, we appreciate CMS continuing to de-prioritize the enforcement of the 96-hour condition of payment and continuing to work with CAHs to improve the flexibility and reduce burdens associated with the 96-hour requirements.

Co-location

We also write to express our concern about the confusion on CMS' varying interpretations of guidance for hospitals regarding co-location and shared space arrangements. We understand that CMS may be in the process of developing guidance to provide greater clarity for providers regarding the parameters for co-location arrangements, and we support CMS in these efforts. We urge CMS to prioritize and promptly release the guidance, especially given hospitals have stated there has been substantial confusion and uncertainty on co-location requirements since 2015. Concerns about CMS' implementation of co-location, arrangements by which providers often share medical space with other providers, were first raised in 2015 – approximately three years ago. The corresponding delay in issuing clarifying guidance has resulted in some hospitals unwinding their co-location or shared service arrangements out of an abundance of caution. This is troubling, as some of these arrangements have been in place for decades and help ensure access to care for patients. In such instances, the area hospital and the physician may reach an agreement whereby the physician has office space in the hospital he or she uses when in town. This arrangement provides access to services for residents in the area and makes efficient use of available space without jeopardizing patient safety – a "win" for patients, the physician, and the hospital.

During our Medicare Red Tape Relief Project roundtables, we heard from multiple providers on this issue, including the impact it has on rural communities. Visiting specialists provide a crucial service in rural communities and commonly provide access to critical care. Allowing visiting specialists to utilize rural hospitals and provider-based clinics is a helpful way to increase access to care in rural areas. There are burdensome requirements and standards for "exclusive use" whereby visiting clinicians may only practice in a facility if patients are provided with a separate entrance and waiting/registration areas, and the space has permanent walls with a distinct suite designation. For small rural facilities, this is often prohibitively expensive or not physically possible. This means that only employed physicians or contracted physicians can easily provide patient care in a provider-based clinic setting, and many providers may be prohibited from co-

locating in the actual hospital setting. This limits access to specialists willing to travel to rural areas to see patients in rural communities.

To address these concerns, we urge CMS to release flexible guidelines regarding co-location arrangements to allow greater access to care and enhance coordinated care for patients, such as allowing visiting specialists to provide care in what is otherwise hospital space or allowing common waiting rooms and passageways that permit patients to easily access different providers. We believe a simpler patient notification would suffice to achieve the goal of this policy without causing rural communities to lose access to care.

We urge the Agency to ensure a common-sense approach to the shared use of common spaces (*e.g.*, waiting rooms, reception areas, main building hallways). There appears to be limited health and safety implications involved in arrangements whereby employees of one entity walk past an area controlled by another entity (*e.g.*, employees of Entity A walking past an open therapy area used by Entity B). If the same arrangement would be acceptable if the hospital owned therapy Entity B, then the arrangement should not be of concern under separate ownership.

Hospital Star Ratings for Rural Hospitals

Another issue we heard about during our Medicare Red Tape Relief Project roundtables was confusion surrounding hospital star ratings for rural hospitals. We encourage CMS to make clearer on the Hospital Compare Website why 20 percent of hospitals (937 facilities) do not receive star ratings. The majority (671) of the facilities with no star rating are CAHs. In our discussion with stakeholders representing these facilities, we learned patients mistakenly misinterpret the lack of a star rating to mean a rural hospital is poor quality when, in actuality, there are too few measures or measure groups to calculate a star rating or measure group score. We believe that minor improvements to the website could reduce confusion to ensure there is no misperception of low quality and avoid any mistaken belief that a rural hospital failed to comply with required reporting. Specifically, we encourage CMS to work closely with both rural hospitals and Medicare beneficiaries to develop improvements to the website for rural hospitals that do not qualify for a star rating. For instance, CMS could test language through focus groups or other means in order to make improvements and ensure that the website is easily understandable to Medicare beneficiaries, including those looking to access hospitals in rural areas.

Additionally, we encourage CMS to work to find ways to appropriately score small and rural facilities by creating measurements tailored for rural hospitals and the unique patient volumes and services provided at rural hospitals.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Laws and rules governing rural health clinics (RHCs) and federally qualified health centers (FQHCs) have gone a long time without any updates. As we in Congress work to identify issues in statute that may limit the ability for these important rural providers to see patients and utilize new innovations and technologies to further access, we hope that we can begin a dialogue with you on how changes can be made in the regulatory space to these ends, as well.

We look forward to continuing to work with CMS to ease burdens on rural providers to promote better access to care in rural communities.

Sincerely,

ADRIAN SMITH
Member of Congress
Committee on Ways and Means

PETER J. ROSKAM
Chairman
Subcommittee on Health
Committee on Ways and Means

CC: The Honorable Mick Mulvaney, Director
White House Office of Management and Budget
The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services